COVID–19

Outbreak Guidance for Long-Term Care Homes

If you have any questions, please contact:

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Introduction

The goal of this document is to provide guidance and best practice recommendations to assist the staff of Yukon's long-term care (LTC) homes to respond to outbreaks of COVID-19 within these settings, limiting transmission to residents and staff within the home. It is meant to provide a set of interventions for LTC COVID-19 outbreaks, building on existing approaches to respiratory outbreaks, available evidence on COVID-19, and current national and international experience with COVID-19 control in these settings. This guidance is not prescriptive and should be applied in the context of a specific outbreak scenario in conjunction with Yukon's Medical Officers of Health (MOH) and Yukon Communicable Disease Control (YCDC).

This document does not provide guidance for the clinical management of COVID-19 cases nor outbreaks in assisted living facilities and other contexts.

This guidance document is based on the latest available scientific evidence about this disease and is subject to change as new information becomes available. The Public Health Agency of Canada is posting regular updates and related documents at www.phac-aspc.gc.ca . The Government of Yukon also provides updated COVID-19 related information on its website www.yukon.ca/covid-19 .

In Yukon, under the Public Health and Safety Act, the Chief Medical Office of Health (CMOH) and designate has the authority to make orders and establish rules and guidelines to protect and promote the health of Yukon residents. For ease of use in this document, the CMOH and the Deputy Chief Medical Officer of Health (DCMOH) will be referred to as the Medical Officer of Health (MOH).

Current evidence suggests that the incubation period for COVID-19 is one to 14 days with a median of five to six days. The period of communicability of COVID-19 has not been definitively established. For the purpose of outbreak management in LTC homes, the period of communicability for individuals infected with COVID-19 is considered to begin 48 hours prior to symptom onset to 10 days after onset of symptoms. Live viral shedding may occur for longer in those with illness of greater severity (e.g., admitted to hospital directly due to COVID-19) and those who are severely immunocompromised, and the period of communicability may extend to 20 days after onset of symptoms in these groups See Interim Guidance- COVID-19 public health management of cases and contacts.

Definitions

LTC COVID-19 SUSPECTED OUTBREAK:

One resident or staff of a long-term care (LTC) home has a lab-confirmed COVID-19 diagnosis, regardless of epidemiological link. If the case of lab-confirmed COVID-19 is in a staff member, that staff member must have been at the LTC home during the period of communicability.

LTC COVID-19 OUTBREAK:

Evidence of transmission between one or more residents or staff of a long-term care (LTC) home. Transmission could be:

- Staff to staff
- Staff to resident
- Resident to resident
- Resident to staff

OUTBREAK STAGES:

1. **Declared Outbreak:** The MOH holds the authority to declare an outbreak in a LTC home.
2. **Concluded Outbreak:** The MOH holds the authority to declare an outbreak over in a LTC home. Generally, this will be 14 days, i.e., two mean incubation periods with no new cases after the last date of exposure to a lab-confirmed COVID-19 case at the LTC home.

   The length of time to conclude an outbreak may be reduced or extended at the direction of the MOH; for example, a facility with one staff member diagnosed with COVID-19 AND zero (0) residents, may have an outbreak concluded 14 days after last exposure to the symptomatic staff member at the discretion of the MOH.

PRESENTATION DEFINITIONS:

1. **Influenza-like illness (ILI):**
   New or worsening cough with abnormal temperature or a temperature that is abnormal for that individual and one or more of the following:
   - Myalgia (muscle pain)
   - Arthralgia (joint pain)
   - Prostration (physical or/and mental exhaustion)
   - Sore throat
2. **Respiratory infection:**
   Includes new/acute onset of any of the following symptoms:
   - Cough (or worsening cough)
   - Fever and chills
   - Shortness of breath/difficulty breathing
   - Sore throat or hoarse voice
   - Headache
   - Rhinorrhea (runny nose) or nasal congestion, not otherwise explained
   - Gastrointestinal symptoms, such as vomiting or diarrhea, not otherwise explained
   - Fatigue/muscle aches

- Loss of sense of taste and/or smell

3. Fever without known cause:
   - Fever or a temperature that is 1°C above normal for that individual without other known cause. (Does not include fever associated with known cause such as urinary tract infection.)

PRACTICE POINT

Fevers are not usually present in the majority of the LTC resident population.

A temperature of less than 35.6C or greater than 37.4C in the elderly may be an indication of infection.

Elders may also have an atypical presentation including: delirium, confusion, falls, functional decline, decrease in blood pressure, hypoxia without respiratory symptoms

PPE FOR CARING FOR RESIDENTS WITH PROBABLE, SUSPECT OR CONFIRMED COVID-19

In response to COVID-19, Yukon Continuing Care has a Continuous Mask Use process recommended by the MOH, which recommends health-care workers (HCW) in LTC homes who have contact with residents during the course of their shift must wear a surgical/procedure mask at all times and discretionary N95 use is supported. This is in addition to point-of-care risk assessments and other infection prevention and control processes, such as droplet and contact precautions. LTC managers and staff are advised to refer to the current PPE guidance when caring for residents suspected or confirmed to have COVID-19.

MONITORING OF AND INITIAL RESPONSE TO PROBABLE OR SUSPECT COVID-19 CASES (SYMPTOMATIC, PRIOR TO LAB TEST RESULT)

Monitoring for COVID-19 cases

LTC staff should actively monitor residents daily for compatible symptoms/presentations (see definitions section) associated with COVID-19. Residents who meet the above-mentioned case definitions are considered possible cases and should be tested for COVID-19 via a nasopharyngeal swab (NP) swab.

PRACTICE POINT

It is important to consider respiratory infection (RI) outbreak definitions in the context COVID-19.
If you have two or more residents/staff whose symptoms meet the existing RI outbreak definition and COVID-19 testing criteria, this situation would meet the definition of a RI outbreak.
See Outbreak Management in Residential and Acute Care Settings Guidance documents

LTC staff should test residents experiencing mild ILI or respiratory symptoms, as well as fever without a known cause, and residents experiencing atypical symptoms. COVID-19 cases in the LTC population are known to occur with mild or atypical presentations.

All persons who enter LTC homes are expected to follow existing guidelines for screening including having signs/symptoms of COVID-19 assessed upon entrance. Entrance should not be provided to persons who are experiencing symptoms.

INITIAL STEPS FOR SUSPECT CASES

Review the current criteria and processes for testing and isolating residents in COVID-19 recommendations for long-term care facilities – residents. As outlined in this document, the LTC home should institute the following:

1. Immediate controls, isolation
   - **Isolate** the resident in their room.
   - **Follow** droplet and contact precautions and use appropriate personal protective equipment. Staff who are entering the room of a patient awaiting COVID-19 testing must follow droplet and contact precautions. This includes:
     - Gloves
     - Long-sleeved cuffed gown (cover front of body from neck to mid-thigh)
     - Procedure/surgical mask (already worn due to mask during all of shift)
     - Face/eye protection (i.e. face shield, mask with attached visor, non-vented safety glasses, or goggles)
     - N95 respirators/Max Air are only necessary when conducting an AGMP
   - **Setup** a PPE station, in an easy-to-access location (i.e. outside of resident's door.)
   - **Post** droplet and contact precaution signs on the door of the resident's room.

PRACTICE POINT

PPE is one of a hierarchy of controls aimed at removing or eliminating hazards to HCWs from infectious disease exposures, which includes training and administrative controls (i.e., isolation policies and procedures). Consistent adherence to donning (putting on) and doffing (taking off) of PPE is a basic yet vital step that protects staff health and reduces the risk of healthcare-associated infections.

2. Test resident
   - **Obtain** a nasopharyngeal (NP) swab specimen.
     - The swab should be obtained as soon as possible after symptom onset. Be aware, the chance of false negative test result may occur early in the disease process; swabs may need to be collected again 48 hours after symptom onset.
     - Ensure LTC staff use existing requisitions in place to ensure prioritized testing.
     - Transportation of specimens can be facilitated by exiting process.

3. Continued surveillance
   - **Continue** active monitoring of all residents for symptoms once daily: LTC home should maintain an increased level of surveillance of other residents who fit the above mentioned presentations.
   - **Documentation of resident and staff monitoring:** LTC home should maintain a line list of all symptomatic residents (see Appendix A) and a separate line list of symptomatic staff (see Appendix B).

PRACTICE POINT

To enable quick use of the line list, preparing the resident line lists in advance (pre-populating the demographics of all the residents on the line list), should be considered. If a COVID-19 Outbreak is called, reporting to YCDC will require ALL residents (symptomatic or not).

4. Continued resident care
   - **Restrict** symptomatic residents to their room, this includes meal time and other activities.

5. Notification
    - **Notify** leaders in resident care for the LTC home (Outbreak Management Team, Infection Control Nurse)
    - **Notify:**
        - Resident's primary care provider: Direct LTC staff to notify resident's usual primary care provider to determine if further assessment and treatment is indicated.
        - Resident's family / substitute decision-maker / next-of-kin: Direct LTC staff to notify family of illness and testing being done.
        - Scan completed COVID-19 LTC resident reporting form including client demographic information and e-mail to HSS-CC-OutbreakSurveillance-email
        - CC-Outbreak Surveillance group: reviews form, seeks additional information as required and provides update to YCDC (YCDCSurveillance@yukon.ca.)

6. Continued management of the facility/residence
    - **Cleaning:** Inform housekeeping of the need for enhanced cleaning[1].
    - **Continue** the existing screening for all LTC staff: LTC home should be on alert for staff who fit the above mentioned presentations.
    - Staff with ILI, respiratory illness or fever should be excluded from the LTC home and referred for testing as per the existing testing recommendations.
    - Advise the staff to identify themselves as LTC staff when being assessed for testing.

It is important to note if tests results come back COVID-19 negative, routine Outbreak Management in Residential and Acute Care Settings Guidance documents should be applied.

Managing a Suspected COVID-19 Outbreak

Yukon Communicable Disease Control (YCDC) is notified of all lab-positive COVID-19 cases by the lab performing the test and will lead and coordinate the investigation of all positive cases.

A single lab-confirmed COVID-19 case in a resident or staff who worked during their period of communicability (POC) is considered a suspected outbreak unless otherwise directed by the MOH.

The primary goal in declaring a suspected outbreak is to ensure no further transmission occurs within this vulnerable setting. This is achieved through an implementation of targeted precautions/measures in a timely matter. There will be continued surveillance and an investigation to determine the source of infection. Over defined period of time there will either be evidence of transmission within this setting (outbreak) or the suspected outbreak will be declared over with a resumption of routine practices.

The MOH is responsible for declaring the suspected outbreak and determining when to close and reopen the facility to admissions and transfers. The care facility should alert service providers and others as appropriate (e.g. EMS, Whitehorse General Hospital, oxygen delivery services, pharmacy) that the facility is under outbreak protocols.

• All suspected outbreak control measures shall take priority over routine operations until the outbreak is declared over.

- All restrictions shall remain in place until the suspected outbreak is declared over by the MOH.

Positive COVID-19 test in one resident

CONTROL MEASURES

1. Immediate controls, isolation
   - **Isolate** all residents on the house/pod/unit until directed otherwise by YCDC. Avoid the use of multi-person/shared rooms. If this cannot be accommodated contact YCDC for further discussion and immediate management.
     - **Test all** symptomatic residents and staff. Asymptomatic testing of residents should occur 3-5 days after known exposure. Asymptomatic testing of staff to be done as per the direction of the MOH/YCDC.
     - Note mild symptoms in residents or atypical/unusual symptoms for assessment.
   - **Set up** PPE stations.
   - **Post** droplet and contact precautions signage throughout the unit including the entrance and on the door of resident rooms.
   - **Ensure that** droplet and contact precautions are in place for all affected residents.
   - **Post** COVID-19 suspected outbreak signage throughout the facility specifically at access points instructing staff and essential volunteers and visitors:
     - NOT to enter if they have any signs or symptoms of illness, as defined on the current COVID-19 recommendations for long-term care facilities.
     - NOT to enter if they have been instructed to self-isolate or self-quarantine.
     - To practice hand hygiene and put on a procedure mask on entry.
   - **Identify** any resident/staff who are no longer on the unit, but who have been on the unit in the period of communicability as defined by YCDC.
   - **Encourage** diligence in strict adherence to hand washing and use of alcohol-based hand sanitizer (70%) for all patient/residents/staff.

PRACTICE POINT

Testing immediately (1-2 days) after an exposure is not recommended.
It will most likely result in a negative result, as viral load would not be detectable so early after exposure. Asymptomatic testing, when indicated, should be done 3-5 days after exposure to have a likely more accurate result.

2. Continued surveillance
   - **Increase** active resident and staff monitoring to twice daily. LTC home should maintain an increased level of surveillance of other residents and staff who fit the above mentioned presentations.
     a. Implement droplet and contact precautions and test for COVID-19.
     b. Exclude any symptomatic staff from the workplace. Staff with any signs/symptoms of possible COVID-19 infection **no matter how mild**, should be excluded from the LTC home and referred for testing as per the existing testing recommendations. Advise the staff to identify themselves as LTC staff when being assessed for testing.

3. Continued resident care
   - **Continue** enhanced cleaning for unit/floor. Consider expanding to include the entire facility.

- **Encourage** diligence in hand washing and use of alcohol-based hand sanitizer for all patient/residents/staff.

4. Notification/communication
   - **Working** with the Continuing Care Outbreak team, send the COVID Line List form for all residents (see Appendix A) to YCDC (YCDCSurveillance@gov.yk.ca) daily.
   - **Working** with the Continuing Care Outbreak team send COVID Line List form for staff (see Appendix B) to YCDC (YCDCSurveillance@gov.yk.ca) daily.
   - **Alert** supply chain staff (PPE supplier) that additional hand hygiene products, gloves, gowns, eye protection and masks may be required.
   - **Notify** non-facility staff, professionals, and service providers of the outbreak and assess their need to visit the LTC home. Every effort should be made to avoid unnecessary entry into the home, and if entry is required, delivery personnel are screened as per other visitors. Visits should be postponed unless:
     - It is to provide an essential therapeutic service that cannot be postponed without adversely affecting the health of the residents.
     - It is to provide essential services (i.e. maintenance, etc.) to maintain the safe operation of the facility.
   - **Track/Log** all persons (staff/visitors/essential service providers etc.) within the home including date of access, signs/symptoms, purpose of entry and entry and exist time.

5. Continued management of the unit/facility
   - **Communicate** with families of residents about the suspected outbreak and the risk (see Appendix C).
   - **Discuss** outbreak with daily scheduled check with YCDC.
   - **Restrict** visitors to the LTC unit.
     - Visitors who are essential to the direct care and well-being of residents, such as those who provide feeding care, may be considered, on a case-by-case basis in consultation with the MOH.
     - Based on the trajectory of the outbreak and on a case-by-case basis, end-of-life visits may be considered in consultation with the MOH.
   - **Close** unit/pod to admissions and transfers. Any request for admission or re-admission must be discussed with the MOH. Transfer of residents from an outbreak unit to another unit or LTC home is not recommended until the outbreak is declared over. Any exceptions should be discussed with the MOH.
   - **Ensure** LTC home staff are not actively working in other healthcare settings. Cohort staff to the outbreak unit. Staff are not to work in any other unit/facility until the outbreak is declared over (see Appendix D).
   - **Restrict** staff movement throughout home (no staff coverage between units/floors).

PRACTICE POINT

YCDC in conjunction with the MOH will determine the period of communicability for any isolated resident this includes both onset and resolution. These decisions are multifactorial. The decision to remove isolation may include a non-test based strategy or a test-based strategy. Both approaches require resolution of fever (without use of fever-reducing medication) AND improvement in symptoms (respiratory, gastrointestinal, and systemic).

Consultation is required prior to discontinuing any precautions.

Provision of medically necessary/acute health services should proceed. Consideration should be given to defer the visit if appropriate or support virtual care whenever possible. On-site visits should be evaluated to ensure the necessity of the intervention and adjustments that may need to occur to support safety of the providers and the residents.

CONTACT TRACING

For the purpose of contact tracing within the LTC setting, all residents and staff on the affected unit will be managed as contacts. In addition, Continuing Care must identify any additional persons (including visitors, family, staff or residents) who have had close contact with the confirmed COVID-19 positive resident (e.g. taking meals together, face-to-face conversations and other close contact), and provide this information to YCDC for further management.

As a part of outbreak management all residents in the affected unit/pod of the LTC home will be tested regardless of whether or not they have signs/symptoms. They will be considered exposed and should be monitored closely, with symptom checks by LTC staff performed twice daily for the duration of the outbreak or until advised to stop by YCDC. Residents should be confined to their rooms and cared for using droplet and contact precautions.

Residents exposed to a confirmed case should not be transferred to any other room for 14 days after the last exposure to an individual diagnosed with COVID-19.

Continuing Care will provide YCDC a list of all staff and their contact information who worked within the period of communicability as defined by YCDC. Staff will be advised of testing recommendations by YCDC and all staff who work on the affected unit within the period of communicability will be offered testing regardless of whether or not they have signs/symptoms. YCDC will contact staff and visitors respectively and provide recommendations for self-isolation and/or return to work or work self-isolation.

WORK SELF-ISOLATION

(adapted from Government of Ontario)

In exceptional circumstances, asymptomatic staff critical to operations, but who have been advised to self-isolate (either from travel, high-risk exposure, or testing positive), may be directed to “work self-isolation”. Work self-isolation means continuing to work (where appropriate) while using appropriate personal protective equipment and undertaking active self-monitoring, including taking their temperature twice daily to monitor for fever. (See Appendix E) for PPE recommendations for staff on work self-isolation. If symptoms develop while at work, the employee should immediately self-isolate (i.e., remove themselves from providing care). Wash their hands and then put on a mask (if not already in place) and inform their immediate manager/supervisor and/or occupational health and arrange to leave the workplace as soon as possible.

Positive COVID-19 test result in one staff member

YCDC is notified of all new lab-positive COVID-19 cases by the lab performing the test and will investigate all positive cases.

A suspected outbreak will be considered if a staff member with a laboratory-confirmed COVID-19 diagnosis worked during their period of communicability with potential gaps in preventive measures (e.g. without appropriate use of continuous masking or having other unknown or questionable practices)or having widespread contact with other staff members within the work setting.

- All suspected outbreak control measures shall take priority over routine operations until the outbreak is declared over.
- All restrictions shall remain in place until the outbreak is declared over by the MOH.

OUTBREAK CONTROL MEASURES

1. Immediate controls, isolation

- **Isolate** all residents on the house/pod/unit where the staff member worked until directed otherwise by YCDC. Avoid the use of multi-person/shared rooms. If this cannot be accommodated contact YCDC for further discussion and immediate management.
    - **Test all** symptomatic residents and staff. Asymptomatic testing of residents should occur 3-5 days after known exposure. Asymptomatic testing of staff to be done as per the direction of the MOH/YCDC.
    - Gather list of staff working on the date(s) of exposure.
    - Note mild symptoms in residents or atypical/unusual symptoms for assessment.
- **Set up** PPE stations.
- **Post** droplet and contact precautions signage throughout the unit including the entrance and on the door of resident rooms.
- **Ensure that** droplet and contact precautions are in place for all affected residents.
- **Post** COVID-19 suspected outbreak signage throughout the facility specifically at access points instructing staff and essential volunteers and visitors:
    - NOT to enter if they have any signs or symptoms of illness, as defined on the current COVID-19 recommendations for long-term care facilities.
    - NOT to enter if they have been instructed to self-isolate or self-quarantine.
    - To practice hand hygiene and put on a procedure mask on entry.
- **Identify** any resident/staff who are no longer on the unit, but who have been on the unit in the period of communicability as defined by YCDC.
- **Encourage** diligence in strict adherence to hand washing and use of alcohol-based hand sanitizer (70%) for all patient/residents/staff.

PRACTICE POINT

Testing immediately (1-2 days) after an exposure is not recommended.
It will most likely result in a negative result, as viral load would not be detectable so early after exposure. Asymptomatic testing, when indicated, should be done 3-5 days after exposure to have a likely more accurate result.

2. Continued surveillance

- **Increase** active monitoring of residents and staff, monitoring to twice daily. LTC home should maintain an increased level of surveillance of other residents and staff who fit the above mentioned presentations.
    - Implement droplet and contact precautions for residents and test for COVID-19.
    - Exclude any symptomatic staff from the workplace. Staff with any signs/symptoms of possible COVID-19 infection **no matter how mild**, should be excluded from the LTC home and referred for testing as per the existing testing recommendations. Advise the staff to identify themselves as LTC staff when being assessed for testing.

3. Continued resident care

- **Consider** cohorting COVID-19 residents and staff if appropriate. This may include cohorting ill residents to one area or staff to work with symptomatic or asymptomatic residents. Restrict movement of staff between symptomatic and asymptomatic residents as much as possible.

- **Serve** meals to all residents using in-room tray service. If in-room meal service is not possible for some residents due to safety concerns (such as choking hazards), or if feeding is required, the dining room can be used as long as the following conditions are met:
    - No more than 10 persons are in a space at a time. A two-metre distance is maintained between those present.
      AND
    - Those present are asymptomatic and not considered a close contact to a case.
- **Continue** enhanced cleaning for unit/floor. Consider expanding to include the entire facility.
- **Encourage** diligence in hand washing and use of alcohol-based hand sanitizer for all patient/residents/staff.

4. Notification/communication

- **Working** with the Continuing Care Outbreak team **send COVID Line List** form for all residents (see Appendix A) to YCDC (YCDCSurveillance@gov.yk.ca) daily.
- **Working** with the Continuing Care Outbreak team **send COVID Line List** form for staff (see Appendix B) to YCDC (YCDCSurveillance@gov.yk.ca) daily.
- **Notify** non-facility staff, professionals, and service providers of the outbreak and assess their need to visit the LTC home. Visits should be postponed unless:
    - It is to provide an essential therapeutic service that cannot be postponed without adversely affecting the health of the residents.
    - It is to provide essential services (i.e. maintenance, etc.) to maintain the safe operation of the LTC home.
- **Communicate** with families of residents of the outbreak and risk (see Appendix C).
- **Discuss** suspected outbreak with daily scheduled check-in with YCDC.

5. Management of affected unit/facility

- **Ensure** LTC home staff are not actively working in other healthcare settings. Cohort staff to the outbreak unit. Staff is not to work in any other unit/facility until the outbreak is declared over. (Sample letter template provided – Appendix D).
- **Restrict** staff movement throughout the LTC home (no staff movement between units/floors).
- Continue enhanced cleaning for unit/floor.
- **Restrict** visitors to the LTC unit.
    - Visitors who are essential to the direct care and well-being of residents, such as those who provide feeding care, may be considered, on a case-by-case basis in consultation with the MOH.
    - Based on the trajectory of the outbreak and on a case-by-case basis, end of life visits may be considered in consultation with the MOH.
- **Close** LTC home to admissions and transfers. Any request for admission or readmission must be discussed with the MOH. Transfers of residents from an outbreak unit to another unit or LTC facility is not to occur until the suspected outbreak is declared over.

Provision of medically necessary/acute health services should proceed. Consideration should be given to defer the visit if appropriate or support virtual care whenever possible. On-site visits should be evaluated to ensure the necessity of the intervention and adjustments that may need to occur to support safety of the providers and the residents.

YCDC in conjunction with the MOH will determine end date to the period of communicability for any isolated staff member.

ADDITIONAL MEASURES

COVID-19 cohorting: Early in an outbreak, consider options for cohorting LTC residents diagnosed with COVID-19 in consultation with YCDC.

CONTACT TRACING

For the purpose of contact tracing within the LTC setting, all residents and staff on the affected unit will be managed as contacts. In addition, Continuing Care must identify any additional persons (including visitors, family, staff or residents) who have had close contact with the confirmed COVID-19 positive staff member (e.g. taking meals together, face-to-face conversations and other close contact) and provide this information to YCDC for further management.

As a part of outbreak management all residents in the affected unit/pod of the LTC home will be tested as per direction of YCDC and MOH. They will be considered exposed and should be monitored closely with symptom checks by LTC staff twice daily for the duration of the outbreak or until advised to stop by YCDC. Residents should be confined to their rooms and cared for using droplet and contact precautions.

Residents exposed to a confirmed case should not be transferred to any other room for 14 days after last date of exposure to the individual.

Continuing Care will provide YCDC a list of all staff and their contact information who worked within the period of communicability as defined by YCDC. Staff will be informed of the testing recommendations by YCDC and all staff who work on the affected unit within the period of communicability will be offered testing as per direction of YCDC and MOH. YCDC will provide direction for staff and visitors including recommendations for self-isolation and/or return to work or work self-isolation.

WORK SELF-ISOLATION

(adapted from Government of Ontario)

In exceptional circumstances for asymptomatic staff who are critical to operations, but who have been advised to self-isolate (because of travel, high-risk exposure, or testing positive), "work self-isolation" means continuing to work (where appropriate) while using appropriate personal protective equipment and undertaking active self-monitoring, including taking their temperature twice daily to monitor for fever. (See Appendix E) on PPE recommendations for staff on work self-isolation. If symptoms develop while at work, the employee should immediately self-isolate (i.e., remove themselves from providing care). Wash their hands and then put on a mask (if not already in place) and inform their immediate manager/supervisor and/or occupational health and arrange to leave the workplace as soon as possible.

RETURN TO WORK

Staff may return to work as directed by YCDC. YCDC will not release the personal health information of employees to the employer other than written documentation the employee can resume regular work activities without restrictions.

DECLARATION OF A COVID-19 OUTBREAK

An outbreak of COVID-19 will be declared by the MOH if there is evidence of transmission within a continuing care setting. All actions initiated during a suspected outbreak are to be continued and additional precautions or surveillance may be initiated at the discretion of the MOH. All actions are to be continued until the outbreak is declared over by the MOH.

In the context of a confirmed ongoing outbreak, consideration can be given to removing isolation for residents who have completed their isolation periods and been deemed non-infectious, dependent on MOH/YCDC support and ability to operationalize the approach within the affected location.

RESIDENT ADMISSION OR TRANSFER DURING COVID OUTBREAK

Admissions/transfers into the outbreak unit are **suspended** until the outbreak is declared over by the MOH. Any transfers or admissions that are urgently required must be discussed on a case-by-case basis with the MOH. **Transfer of residents from an outbreak unit to other LTC homes or units is not to occur until the outbreak is declared over in that unit/home.**

For transfers to acute care: Residents who require urgent medical attention that cannot be met in the LTC home should wear a mask, if possible, during transport. The LTC home should notify the Emergency Department at the receiving facility to coordinate medical management of the resident. Staff must notify the Emergency Department regarding the resident's infection status. Staff must inform Emergency Medical Services (EMS) and the receiving facility of the following:
a) Reason for transfer to acute care.
b) Resident is in a LTC home with an ongoing COVID-19 outbreak.
c) If resident is symptomatic or not.
d) If the resident has been tested for COVID-19 and the results, if available.
e) If the resident is a close contact to the index case (i.e. roommate to a COVID-19 case.)
In addition to routine practices, HCWs involved in transporting the resident should wear PPE for droplet and contact (a surgical/procedure mask, eye protection, gown and gloves).

For transfers from acute care back to a LTC home under COVID-19 precautions: Acute care site should contact the MOH or their designate to discuss the transfer.

Readmission of a COVID-19 case back to the LTC may be considered on a case-by-case basis – contact the MOH to discuss. If transfer request were allowed, residents may be required to remain on isolation for a period of 14 days.

RESIDENT CARE EQUIPMENT

All reusable equipment and supplies, along with personal belongings, will be dedicated to the use of a specific resident.

- If this is not feasible and equipment and supplies are to be shared with other residents, they need to be cleaned and disinfected after each use and between residents.
- Ensure that any materials (e.g. electronic tablets or other devices, craft supplies, magazines, books, tools, etc.) are not shared among residents unless they are cleaned and disinfected between uses for each resident.
- If the items cannot be easily cleaned and disinfected, they should not be shared among residents.
- Items that cannot be properly cleaned and disinfected can be dedicated to the resident and then discarded upon resident transfer or discharge.
- At discharge, room transfer, or death of a resident, any resident-owned items (e.g. clothing, photos, televisions, furniture, cards and ornaments) should be removed, any items with hard surfaces cleaned, and items placed in a bag for family or representative.
- While risk of transmission of COVID-19 via these items is likely low, it is recommended that families store the items for five days prior to handling.

- If the family wishes to donate any of the resident's items to the LTC home or another resident, they must first be thoroughly cleaned and disinfected.
- Discard single-use disposable equipment into a no-touch waste receptacle after use.

DRESS CODE

As a part of a facilities' safety plan, strong consideration should be given to implement a standardized approach to dress code, specifically for all staff providing direct care (e.g., care aides nurses, physicians, allied health care staff etc). This approach is for the individuals' own protection and the protection of others and supports existing infection presentation practices. See (Appendix F).

PUBLIC COMMUNICATIONS

In the context of COVID-19, the CMOH provides regular updates on COVID-19 cases to the public. In addition, and in conjunction, with senior management, the Communications branch provides coordinated responses to media inquiries. Only designated, predetermined staff members are permitted to speak with media outlets.

OUTBREAK MANAGEMENT TEAMS

Multidisciplinary outbreak management teams are part of Infection Prevention and Control Canada's (IPAC) Standards for Infection Prevention and Control programs. To facilitate communication and coordination of outbreak control measures, an outbreak management team should be established when an outbreak is declared.

COVID-19 SURGE PLAN

During an outbreak, demands on the facility to provide care to residents may exceed the facility's resources and ability to provide safe and appropriate care. In particular, staffing may be an issue due to exclusion of COVID positive staff from the facility.

If the LTC home has commenced its outbreak response plan but demands for resources (HR or otherwise) have escalated beyond its capacity, the impacted LTC home may activate the response plan to request support for the facility.

Response plans can mobilize different strategies including local staff redeployment, agency staffing, financial incentives, and volunteers within Continuing Care Branch, as well as Health and Social Services, wider Yukon government or other HCWs within Yukon.

POST-OUTBREAK DEBRIEFING

After the conclusion of an outbreak, consider a debriefing meeting to evaluate the management of the COVID-19 outbreak and make recommendations to further COVID-19 outbreak management guidance. Participants should include: LTC home staff, management, YCDC and the MOH.

LTC staff should continue the active monitoring of residents at least once daily for compatible symptoms/ presentations (see 'definitions' section) despite the outbreak being declared over in order to recognize whether illness is reintroduced into the facility. All staff, physicians, volunteers, and contractors working on the site, regardless of role or resident contact, will be subject to screening to ensure no one is presenting with illness as outlined in the existing LTC Screening Criteria. Residents who meet the above-mentioned case definitions are considered possible cases and should be tested for COVID-19 via a nasopharyngeal swab (NP) swab.